

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
- F. Title insurance;

- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, “Financial guaranty insurance” includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, “credit insurance” means insurance on accounts receivable.

The terms “disability insurance” and “accident and health insurance,” and “health insurance” are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: “Ocean marine insurance” means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

- A. *“Account” means any one of the three accounts created by Section 6.]*

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. “Association” means the [State] Insurance Guaranty Association created under Section 6.
- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

Drafting Note: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).

D. **[Alternative 1]** “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Alternative 2] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

E. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

F. “Commissioner” means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term “commissioner” appears.

G. “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

H. “Covered claim” means the following:

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and

(a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or

(b) The claim is a first party claim for damage to property with a permanent location in this State.

(2) Except as provided elsewhere in this section, “covered claim” shall not include:

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

- (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the State of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

- I. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

- J. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

- K. (1) “Member insurer” means any person who:
 - (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer’s license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer’s license.

- L. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

- M. “Novation” means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

- N. “Person” means any individual, aggregation of individuals, corporation, partnership or other entity.

- O. “Receiver” means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

- P. “Self-insurer” means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

- Q. **[Alternative 2b]** “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K~~1~~ shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. *The workers’ compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term “director” shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of

directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of “the business of insurance” similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a *board member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
 - (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.
- (3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-

member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

- (3) **[Alternate 1b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]
- (3) **[Alternate 2b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an

assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

- (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
 - (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
 - (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

- (1) Employ or retain persons as are necessary to handle claims and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) *Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.
- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional Section 8D

D. (1) *The legislature finds:*

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The*

commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

- A.
 - (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
 - (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.

- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
 - (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

- B. The commissioner may:
- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
 - (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
 - (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines “high net worth insured,” has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States’ net worth restrictions pursuant to those States’ guaranty association laws.

- A. For purposes of this section “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of “covered claim.” The Michigan Supreme Court, in interpreting a “net worth” provision in the Michigan guaranty association statute, held that governmental entities possess a “net worth” for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
 - (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise./

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured./
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)

- (a) The credit shall be deducted from the lesser of:
 - (i) The association's covered claim limit;
 - (ii) The amount of the judgment or settlement of the claim; or
 - (iii) The policy limits of the policy of the insolvent insurer./

[Alternative 2 for Section 14A(2)(a)]

The credit shall be deducted from the lesser of:

- (i) The amount of the judgment or settlement of the claim; or
- (ii) The policy limits of the policy of the insolvent insurer.]

(b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

(3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

(4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and

(b) Any amount payable by or on behalf of a self-insurer.

(6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.]

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

- 1970 Proc. I 218, 252, 253-262, 298 (adopted).
- 1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
- 1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
- 1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
- 1979 Proc. I 44, 46, 126, 217 (amended).
- 1981 Proc. I 47, 50, 175, 225 (amended).
- 1984 Proc. I 6, 31, 196, 326, 352 (amended).
- 1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
- 1986 Proc. II 410-411 (amendments adopted later printed here).
- 1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
- 1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
- 1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
- 1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
- 2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. CODE §§ 27-42-1 to 27-42-20 (1981/2009) (Uses separate account option).	
Alaska		ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/2004) (uses separate account option) (previous version of model).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/2014) (previous version of model).
Arkansas		ARK. CODE ANN. §§ 23-90-101 to 23-90-123 (1977/1999).
California		CAL. INS. CODE §§ 1063 to 1063.15 (1969/2013).
Colorado		COLO. REV. STAT. §§ 10-4-501 to 10-4-519 (1963/2002) (uses separate account option) (previous version of model).
Connecticut		CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/2011) (uses separate account option) (previous version of model).
Delaware		DEL. CODE ANN. tit.18, §§ 4201 to 4221 (1982/1991) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
District of Columbia		D. C. CODE §§ 31-5501 to 31-5515 (1993) (previous version of model).
Florida		FLA. STAT. §§ 631.50 to 631.70 (1982/2010) (previous version of model).
Georgia		GA. CODE ANN. §§ 33-36-1 to 33-36-19 (1970/2005).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:16-101 to 431:16-117 (1988/2003) (previous version of model).
Idaho		IDAHO CODE ANN. §§ 41-3601 to 41-3621 (1970/2014) (previous version of model).
Illinois	215 ILL. COMP. STAT. 5/532 to 5/553 (1977/2013) (Uses separate account option).	
Indiana		IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/2013) (uses separate account option) (previous version of model).
Iowa	IOWA CODE §§ 515B.1 to 515B.26 (1970/2010).	IOWA CODE §§ 518C.1 to 518C.19 (2000) (separate fund for state and county mutuals).
Kansas		KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/2005) (previous version of model).
Kentucky		KY. REV. STAT. ANN. §§ 304.36-010 to 304.36-170 (1972/1990) (previous version of model).
Louisiana	LA. REV. STAT. ANN. §§ 22:2051 to 22:2070 (1970/2010).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4431 to 4452 (1969/2009) (uses separate account option) (previous version of model).
Maryland		MD. CODE ANN., INS. §§ 9-301 to 9-316 (1971/1997) (previous version of model); BULLETIN 2012-13 (2012).
Massachusetts		MASS. GEN. LAWS ch. 175D, §§ 1 to 16 (1970/2004) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.7901 to 500.7949 (1969/1982); BULLETIN 2010-10-INS; BULLETIN 2010-04-INS (2010); BULLETIN 2014-12-INS (2014).
Minnesota		MINN. STAT. §§ 60C.01 to 60C.20 (1971/2003) (uses separate account option) (previous version of model).
Mississippi		MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992) (previous version of model).
Missouri		MO. REV. STAT. §§ 375.771 to 375.780 (1971/2013) (uses separate account option) (previous version of model).
Montana		MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971/2013) (previous version of model).
Nebraska		NEB. REV. STAT. §§ 44-2401 to 44-2418 (1971/1990) (uses separate account option) (previous version of model).
Nevada		NEV. REV. STAT. §§ 687A.010 to 687A.160 (1971/2005) (previous version of model).
New Hampshire		N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970/2004) (uses separate account option); §§ 404-H:1 to 404-H:20 (2004) (previous version of model).
New Jersey		N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974/2003) (previous version of model); N.J. INS. ORDER A12-108 (2012); N.J. INS. ORDER A13-110 (2013); N.J. BANKING & INS. ORDER A16-111 (2016).
New Mexico		N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989) (uses separate account option) (previous version of model); §§ 59A-30A-1 to 59A-30A-18 (1999) (Title insurance fund).
New York		N.Y. INS. LAW §§ 7601 to 7614 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/2009) (uses separate account option) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Dakota		N.D. CENT. CODE §§ 26.1-42.1-01 to 26.1-42.1-15 (1999) (previous version of model).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3955.01 to 3955.21 (1970/2005) (uses separate account option) (previous version of model).
Oklahoma		OKLA. STAT. tit. 36, §§ 2001 to 2019 (1980/2014) (uses separate account option) (previous version of model).
Oregon		OR. REV. STAT. §§ 734.510 to 734.710 (1971/2003) (previous version of model).
Pennsylvania		40 PA. CONS. STAT. §§ 41-201 to 41-220 (1995) (previous version of model).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3801 to 3819 (1974/1980) (previous version of model).
Rhode Island	R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/2010) (Uses separate account option).	
South Carolina		S. C. CODE ANN. §§ 38-31-10 to 38-31-180 (1988/2001) (uses separate account option) (previous version of model).
South Dakota		S.D. CODIFIED LAWS §§ 58-29A-54 to 58-29A-109 (2001/2013) (Uses separate account option) (previous version of model).
Tennessee		TENN. CODE ANN. §§ 56-12-101 to 56-12-119 (1971/1999) (previous version of model).
Texas		TEX. INS. CODE ANN. §§ 462.001 to 462.351 (2007) (previous version of model).
Utah		UTAH CODE ANN. §§ 31A-28-200 to 31A-28-220 (1986/2002) (uses separate account option) (previous version of model); UTAH ADMIN. CODE r. 71-3 (1971).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont		VT. STAT. ANN. tit. 8, §§ 3611 to 3633 (1969/1979) (uses separate account option) (previous version of model).
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 231 to 247 (1984/1986) (previous version of model).
Virginia		VA. CODE ANN. §§ 38.2-1600 to 38.2-1623 (1986/2014) (previous version of model).
Washington		WASH. REV. CODE §§ 48.32.010 to 48.32.930 (1971/2005) (uses separate account option) (previous version of model).
West Virginia		W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (uses separate account option) (previous version of model).
Wisconsin		WIS. STAT. §§ 646.01 to 646.73 (1979/2013) (“Insurance Security Fund”).
Wyoming		WYO. STAT. ANN. §§ 26-31-101 to 26-31-117 (1971/2013) (previous version of model).

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A regulator discussed the history of revising this model in relation to the new NAIC model law process. He stated that the draft was re-exposed for new comments. **2008 Proc. 1st Quarter Vol. II 10-440.**

The Financial Condition (E) Committee adopted amendments to this model. The Committee summarized the more significant changes including the Task Force’s recommendation on the assumed business options. **2008 Proc. 4th Quarter Vol. II 10-5.**

The joint Executive Committee/Plenary adopted amendments to this model. A commissioner noted that an interested party provided a comment requesting reconsideration of the optional net worth exclusion provision. The commissioner reiterated that the provision was optional and intended to provide uniform language for states interested in implementing a net worth exclusion. **2009 Proc. 1st Quarter Vol. I 3-5.**

Section 1. Title

Section 2. Purpose

In 1969 the NAIC prepared a statement of position on automobile insurance. One part of that study concerned automobile insurer insolvencies. It was stated that the “... position of the NAIC [is] that no innocent person should suffer as a result of the insolvency of an insurer...” and the association vowed to take action to assure that end. They recommended serious consideration be given to the establishment of an industry facility regulated by the states to guarantee solvency and to indemnify the public against the insolvency of any casualty insurer. A federal guaranty corporation was suggested in a congressional bill, but a resolution was adopted by the NAIC in opposition to this proposal. The resolution emphasized the fact that the NAIC was recommending a program in each state to establish a means to guarantee the payment of claims against insolvent insurers. **1969 Proc. II 549-552.**

Every insurance company failure undermines public confidence in, and the value of, the insurance institution whose continued existence is the result of the public’s desire and need to be secure from risk. Like taxes, the over-all cost of the solvency of an individual company and of such industry-wide schemes as guaranty funds ultimately falls upon the consumer. **1970 Proc. I 262.**

An insurer association recommended that Section 2 be deleted because it added no substance to the model. **1994 Proc. 2nd Quarter 510.**

The working group decided instead to retain the section, but decided to replace the word “avoid” with “the extent provided in this act, minimize.” The group also deleted a phrase that said one of the purposes was “the detection and prevention of insurer insolvencies.”

The working group felt that the two changes made the section better reflect the purpose of the guaranty association. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 3. Scope

In a report comparing losses of insurance companies and banks, it was pointed out that the property/casualty insurance industry is quite different from the life insurance industry. **1969 Proc. II 564.** The first priority was drafting legislation implementing the NAIC position on automobile insurance problems. **1970 Proc. I 252.**

Basic to drafting a model bill is the determination of its scope. What types of insurance and insurers should be included and excluded? The existing bills range from including only automobile insurance to one embracing both life and property coverages. What contacts must there be with the state before recourse may be had against the fund? **1970 Proc. I 263.**

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Section 3 (cont.)

The task force was charged with the task of considering whether the term “direct” needed to be defined. There has been litigation and many questions arising as to the types of coverage considered “direct” by the model act language. Courts have found large self-insured groups who purchase excess and aggregate stop loss coverage to be covered by the guaranty associations since there was no underlying contract of insurance, even though the coverage was more in the nature of reinsurance coverage. **1989 Proc. II 331.**

A. The drafters intended that a state choose the term “health insurance,” “disability insurance,” or “accident and sickness insurance” to conform to the terminology found elsewhere in the insurance code of the state in question. **1973 Proc. I 157.**

Amendments proposed in 1985 were considered a “radical departure” from the original model by the task force chair. The proposed amendments excluded products unless they were specifically listed as included. That meant new products would be excluded unless they fit under a generic term. Some of the items not included under the industry-suggested approach were based on a desire to exclude them, such as financial guarantee insurance. Other exclusions resulted from the belief that, recognizing the extraordinary nature of a guaranty fund, many insured exposures did not represent an extreme hardship to the person involved. Still others may have resulted from drafting difficulties. **1985 Proc. II 473-475.**

By the time the amendments were adopted at the end of 1985, the mechanics of the scope section had changed from the earlier draft. Rather than limiting coverage only to stated types of insurance, the list excluded certain types of coverage. One listed item was removed just before adoption of the model. It had provided an exclusion from the act for errors and omissions insurance for directors and officers of for-profit organizations. **1986 Proc. I 294.**

B. The task force was unanimously in favor of excluding financial guaranty insurance from the coverage of the guaranty fund. **1986 Proc. I 431.**

C. After the insolvencies of two large writers of surety business the federal government urged the NAIC to consider coverage of surety bonds under the guaranty association. It had not been the policy to do so because such bonds were generally associated with commercial ventures. **1986 Proc. I 429.**

D. Clarification of the subsection was made in 1986. Originally the model only said “credit insurance” but the additional language was inserted to make clear other types of collateral protection insurance similar to credit insurance were also originally intended to be excluded. **1987 Proc. I 450.**

E. In 1995 the NAIC considered an amendment to Subsection E to amplify the exclusion of coverage for insurance of warranties or service contracts. This provision was included in the package of amendments adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter 571.**

I. When model amendments were adopted in 1985, consideration was given to adding a subsection to exclude coverage for claims covered under a governmental insurance program. The exclusion was not adopted at that time, but instead Section 12 was amended to add a requirement to exhaust governmental benefits before the guaranty fund would be responsible for the claim. **1986 Proc. I 296, 304.** In 1986 the Section 12 limitation was deleted and the exclusion contained in Subsection I added. **1987 Proc. I 421.**

An industry association suggested that the comment at the end of the section be amended to note that the Life and Health Insurance Guaranty Association Model Act addresses some of the lines of coverage excluded by this provision. **1994 Proc. 2nd Quarter 510.**

When considering amendments to the model in the latter part of 1995, the working group agreed to add a comment at the end of Section 3. It contained a definition of ocean marine insurance for states whose codes did not contain a definition, so that there would be no question as to the coverages encompassed by the exclusion of ocean marine insurance. The working group agreed to limit the exclusion to craft used for commercial purposes. The working group also decided not to include within the

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Section 3 (cont.)

definition coverage written pursuant to the Jones Act or the Longshore and Harbor Worker's Compensation Act. It was the opinion of the group that these coverages were properly classified as workers' compensation insurance. **1995 Proc. 3rd Quarter 586.**

Section 4. Construction

An industry association recommended that Section 4 be deleted because it added no substance to the model act. **1994 Proc. 2d Quarter 510.**

The working group recommended that the section be retained to encourage appropriate construction of the Act by the courts and to lessen the likelihood that courts would strain to interpret the Act in a manner inconsistent with the intentions of the drafters. The group did remove one word so that the model no longer said *liberally* construed. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 5. Definitions

F. "Covered claim" was considered for modification in 1985. An industry draft suggested a net worth exclusion under which no protection was extended to wealthy persons. The draft recommended exclusion of coverage for any claim in favor of a person having a net worth of \$50 million or more. It was their belief that an insured with that much net worth ought to buy insurance intelligently enough so that it would not be insured by an unsound insurer. They suggested it was not good public policy to send bills for such wealthy persons' losses or claims to all of the homeowners and small business insureds to pay. **1985 Proc. II 474.**

The net worth exclusion was adopted because of potential capacity problems for guaranty funds. The advisory committee felt the suggested change would provide a more even balance between those who really need the protection of guaranty funds and giant corporations. **1985 Proc. II 510.**

Just before adoption of the model revisions in December 1985, the Guaranty Fund Task Force voted to remove a net worth limit of \$10 million that had been included in the draft. A net worth provision was added instead to Section 11. **1986 Proc. I 294.**

The National Committee on Insurance Guaranty Funds approved a document called "Guiding Principles for Settling Disputes Between Property and Casualty Insurance Guaranty Associations as to Responsibility for Claims" and asked the NAIC's acceptance of the program. The purpose was to answer questions about which state's fund should handle the covered claim. **1986 Proc. I 457-459.**

A suggestion made to the working group considering amendments to the model in 1994 was to revise the definition of "covered claim" to make it clear that unearned premium claims are covered by the guaranty fund in the state where the policyholder resided at the time the policy was issued. **1994 Proc. 2nd Quarter 510.**

The working group did not follow the suggestion because of a concern that the proposed revised language would be construed to limit the claims that would be covered. **1994 Proc. 3rd Quarter 419.**

Just before adoption of the amendments by the working group, further discussion was held on the suggestion to assign coverage of an unearned premium claim to the guaranty association in the state where the insured resided at the time of issuance of the policy. One regulator said the proposed amendment would place an additional burden on receivers of insolvent insurers, who often must deal with policy records that are unorganized, inadequate or non-existent. Another

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regulator agreed the proposal could cause delays in paying claims and increase the workload of both receivers and guaranty associations. The working group agreed to defer action on the suggestion. **1994 Proc. 4th Quarter 575.**

Amendments were considered again later in 1995 and Paragraph (2) was revised. It clarifies which guaranty association is primarily liable for the claim for property damage and does not narrow coverage. **1995 Proc. 3rd Quarter 586.**

At a hearing on the proposed amendments held in early 1996 one regulator objected to this proposed amendment. An interested party responded that the amendment does not restrict guaranty association coverage, but only determines the guaranty association that has primary responsibility for a property damage claim. The purpose of the amendment is to clarify that the guaranty association in the jurisdiction where the property giving rise to the claim is located has primary responsibility for the claim. **1996 Proc. 1st Quarter 569.**

An association of guaranty funds recommended that the exclusion from “covered claim” be expanded to exclude claims for reinsurance recoveries, contribution and indemnification brought by other insurers and to prohibit insurers from pursuing such claims against an insured of an insolvent company up to the guaranty fund limits. **1994 Proc. 2nd Quarter 510.**

Paragraph (3)(d) was added in the 1994 revisions. It contains a net worth exclusion for first party claims by an insured whose net worth exceeds \$25 million. The association of guaranty funds had suggested \$10 million as the appropriate level. **1994 3rd Quarter 419.**

G. “Insolvent insurer” was modified in 1972 to change the definition from an insurer “authorized” to transact to one “licensed” to transact insurance. It was the intent of the NAIC committee which drafted the bill to provide coverage only for carriers licensed in the state. In other words, coverage was not to be included for unauthorized insurers since they were not subject to the state’s regulation for solvency. “Authorized” might have been construed to include eligible surplus lines insurers. **1973 Proc. I 155.**

At the June 1976 meeting the industry advisory committee submitted a recommendation for an amendment to the definition of “insolvent insurer.” They contended the law was designed to apply to companies being liquidated, but the language of the model was not sufficiently precise to accomplish that limited objective. The suggestion to add specific language to clarify this point was not acted upon at that time. **1978 Proc. I 277.** It was, however, adopted in December 1978. **1979 Proc. I 217.**

The definition was revised in 1994 to require a final order of liquidation with a finding of insolvency. A drafting note explaining that “final order” means an order that has not been stayed was also included in the amendments. **1994 Proc. 3rd Quarter 419.**

H. Paragraph (2) was added in 1994 to incorporate language concerning termination of membership and liability for assessment in the event of a termination. **1994 Proc. 3rd Quarter 419.**

Section 6. Creation of the Association

Section 7. Board of Directors

A. This provision was modified to allow vacancies to be filled by a majority vote of the remaining board members. By the terms of the original model, it would have been necessary to call a meeting of all member insurers, which would have been extremely cumbersome. **1972 Proc. I 480.**

An advisory group was asked to consider the issue of public representation on guaranty association boards in 1992. The committee report recommended against it, but one member proposed that a drafting note be added to include a provision for public representation on the board where the state had a premium tax offset. **1993 Proc. IB 703.**

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Section 7 (cont.)

One member of the advisory group submitted a minority report explaining her reasons for recommending public representation on guaranty association boards. The main reasons given by the consumer representative were because the public ultimately bears the cost of guaranty fund assessments, because a different perspective is needed, and because accountability is needed. **1993 Proc. I 707.**

As a follow-up from that minority report, the working group decided to draft amendments to both the Life and Health Insurance Guaranty Association Model Act and the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, which were designed to add two public representatives as members of the board of directors of the guaranty associations without increasing the overall number of members on the boards. The amendments also addressed potential conflicts of interest by requiring that the public representatives not be employed or contracted by any entity regulated by the state insurance department or required to register as a lobbyist in the state, or related to either. **1993 Proc. 2nd Quarter 619.**

A representative from an association of guaranty funds said an earlier suggestion for public representatives failed to gain support because of a perception that the commissioner was the representative of the public. Another association representative said his organization's position was that it was a public policy question for the legislatures to determine. The underlying question related to the individual members themselves: their expertise, accountability and responsibility. **1993 Proc. 2nd Quarter 619.**

The consumer representative who authored the minority report restated her position. She believed that because the public ultimately bears the burden of insolvencies either through increased taxes or policy surcharges, the public was entitled to representation on the boards. Any problem experienced with incentive to attend meetings or structure of the board should be addressed separately from the overall issue of representation and should not result in a denial of representation of the public. **1993 Proc. 2nd Quarter 619.**

In a letter of comment on the exposure draft providing for public representation, one association said it had developed a position opposed to public representation when the model was originally drafted. The association's position was that there were substantial conflicts of interest in having consumers and other public representatives on the board. The state guaranty funds stand in the shoes of the insolvent insurer and must pay claims and decide coverage issues as the insolvent insurer would have done. Had the insolvent insurer remained solvent, it would not have had consumers involved in its internal claims process. **1993 Proc. 2nd Quarter 605.**

The consumer representative said insurers also faced a conflict of interest because their interests were not aligned with those of policyholders either, but rather with the solvent insurers who paid the assessment. **1993 Proc. 2nd Quarter 619.**

Another insurer association gave conditional support for the amendment. Its experience had been that qualified public representatives can make a positive contribution to board deliberations. The association expressed some concern about selecting qualified individuals who should be knowledgeable about the insurance industry. It recommended the draft be revised to require only one public member, who should not be eligible to serve as the chair of guaranty fund boards. **1993 Proc. 2nd Quarter 604.**

Before the Executive Committee voted on adoption of the amendment regarding public representatives, further discussion took place. The chair of the Financial Condition Subcommittee said the purpose of the amendment was to improve communication among regulators, the insurance industry and consumers on guaranty fund and insurer insolvency issues. The addition of public representatives to the governing boards would provide consumers with access to the guaranty fund process and a direct means to express concerns. The addition of public representatives also recognizes the impact of insurer insolvencies on the general revenues of states and taxpayers. Another commissioner stated that he occupied a position on the guaranty association boards and acted as a public representative since it was his function to protect the public interest. A third commissioner said that public input into the guaranty fund process would be valuable, and that even though the commissioner's function was protection of the consumers, the issue was one of direct public access. He did not favor inclusion of this provision in the financial regulation standards for accreditation. The chair of the subcommittee responded that this was not being recommended. **1993 2nd Quarter 32.**

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Before final adoption the NAIC plenary body considered the matter again. Concern was expressed that this amendment would be required for a state to be accredited. After assurance that the amendments were not being considered, indeed were not even related to financial solvency, the model amendment was adopted. **1993 Proc. 2nd Quarter 12.**

In 1994 language was added to Section 7A to allow the commissioner to appoint the initial members of the board of directors if not selected by the member insurers within 60 days. A provision was also added to allow the commissioner to fill any vacancies in position held by public representatives. **1994 Proc. 3rd Quarter 419.**

Late in 1995 the working group reviewing suggestions for change to the model recommended that Subsection A be amended to simplify the qualifications for serving as a public member of the board of directors of a guaranty association. **1995 Proc. 3rd Quarter 586.**

The amendment to Subsection A was adopted in 1996, as well as the drafting note following the subsection. **1996 Proc. 1st Quarter 573.**

Section 8. Powers and Duties of the Association

One of the major areas of concern when initially drafting the model was the manner in which the guaranty function was to be performed. Should the program be administered by the commissioner or through an industry association? What functions should the group perform? Shall they be authorized to delegate functions to a servicing insurer? **1970 Proc. I 263.**

A. The drafters started with the promise that the first draft should be a post-assessment rather than a prefunded plan. Then a number of decisions needed to be made in determining those assessments. Should insurers be assessed by lines of business? What, if any, should the maximum rate of assessment be? Should assessments be recognized in the making of premium rates? **1970 Proc. I 263.**

Paragraph (3) of this subsection was amended in December 1971. As the model existed before, if the amount raised by a maximum assessment was insufficient to pay all covered claims, the association would have to marshal all the claims before it could make any payment on any one particular claim. Language was added giving the association the right to pay claims in the order it deemed reasonable, thus avoiding administrative problems and delay. **1972 Proc. I 480.**

A second amendment in December 1971 provided that if a company had deferred payment of an assessment due to its financial condition, that company could not pay any dividends to shareholders or policyholders during the period of deferment, and would have to pay the deferred amount as soon as payment would not reduce capital or surplus below required minimums. **1971 Proc. I 480.**

A December 1978 amendment added a sentence to the last paragraph of Subsection A(1) to eliminate claims filed after the final date set by the court for filing claims against the liquidator. **1979 Proc. I 217.**

The model originally contained a \$100 deductible provision that was deleted in December 1980. At the same time a sentence was added at the end of Subsection A(1) to pay only the amount of unearned premium over \$100. The reasoning for this was that certain consumers bore a disproportionate share of the losses; if there were no deductibles, the losses would be borne more equitably by all insureds. The administrative costs of handling the deductibles were high in relation to the amounts involved, sometimes exceeding what would have been paid out in claims. **1981 Proc. I 225, 228.**

The most notable of the amendments to the model act considered in 1994 included deletion of the \$100 deductible for unearned premium claims. **1994 Proc. 4th Quarter 574.**

The working group was asked to consider deletion of the provision that allows the guaranty fund to pay only that portion of an unearned premium claim in excess of \$100. In support of his proposal, the regulator said his state's receiver spent \$91.18 in costs to adjudicate each policyholder claim for the deductible. He said the substantial number of these claims filed also

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Section 8A (cont.)

creates an administrative burden, as well as depleting assets of the insolvent insurer. An industry spokesperson said the industry favored the deductible because it had the effect of spreading the loss due to insolvency and also reduced the cost of each insolvency to the guaranty association. The working group decided to recommend the deletion of the provision for the deductible. **1994 Proc. 3rd Quarter 419.**

Several industry associations commented on the proposal to delete the \$100 deductible and indicated a desire to retain the provision. A regulator responded that the costs to the estate associated with the deductible were out of proportion to any benefit to policyholders. Another regulator said she received numerous complaints from policyholders about the application of the deductible to their claims. Another regulator said that, although guaranty associations might initially derive some cost savings from the deductible, those savings were offset by the cost to the estate, which ultimately results in less money available for distribution to policyholders, guaranty associations and other creditors. Another added that the necessity of processing claims for the deductible unnecessarily prolongs the administration of estates, which is detrimental to the guaranty association. A guaranty association representative argued that the cost savings related to the deductible was important to guaranty associations. He said in one state it was estimated that the deductible had resulted in savings of more than \$13 million. He suggested other options for addressing the issue, including an exclusion of nominal claims from payment by the receiver and lowering the priority of claims for reimbursement of the deductible. He said costs of the guaranty associations are passed on to the public through rate surcharges and premium tax offsets, and that it was appropriate for policyholders to share some of the costs associated with an insolvency. After much discussion the working group decided to dispense with the deductible for unearned premium claims. **1994 Proc. 4th Quarter 574-575.**

The amendments adopted in December 1985 included a revision of this section, including a limit of \$10,000 per policy for claims on return of unearned premiums. The advisory committee also suggested a limit of \$50,000 on non-economic loss, but this suggestion was not adopted. **1986 Proc. I 300, 344.**

In 1986 an alternative provision was drafted to give the liquidator authority to sell a limited optional reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator. To prevent inconsistencies the time period was set for 18 months. **1986 Proc. II 409-411.** This provision was adopted six months later. **1987 Proc. I 421.**

Revisions were made to this section in 1994 to eliminate the alternative section that had been included for states with a provision in the liquidation law giving the liquidator authority to sell a limited extended reporting period for claims made policies. **1994 Proc. 3rd Quarter 424-425.**

The last sentence of the subsection originally read “Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.” That sentence was deleted as being unnecessary and a potential cause of conflict. **1987 Proc. I 450.**

Section 8A(1) was amended to be consistent with the revised definition in Section 5G by replacing “determination of insolvency” with “order of liquidation.” Language was added at the end of Paragraph (1) that provided that the association’s duty to defend ceased upon payment or tender of an amount equal to the lesser of the association covered claim limit or the applicable policy limit. **1994 Proc. 3rd Quarter 419.**

Late in 1995 a working group considering amendments to the model discussed a proposal from a group suggesting a change to the provision regarding the date at which liability to the guaranty association is cut off and discussed the exclusion from coverage of policyholder protection claims. After lengthy discussion the regulators decided not to recommend the proposed amendments. The group also considered amending Paragraph (1)(b) to provide for an aggregate limit of \$10 million per insured. **1995 Proc. 3rd Quarter 586.**

Members of the working group expressed their support for the idea of an aggregate limit per insured in general, but raised some specific concerns with the proposal. These concerns included the difficulty of application of the aggregate limit if not adopted uniformly by all states and whether the amendment would create an incentive for a guaranty association to delay

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Section 8A (cont.)

claim payments so that payments by other guaranty associations would satisfy the limit, thereby avoiding its statutory responsibility. Another concern was that guaranty association coverage would be exhausted by those who filed claims early, leaving other claimants without any coverage. **1996 Proc. 1st Quarter 569.**

The working group decided to adopt the proposed package of amendments without including the aggregate limit, but to consider a revised proposal in the future. **1996 Proc. 1st Quarter 570.**

A provision was added to Paragraph (2) authorizing the association to pursue and retain salvage and subrogation as to claims paid by the association. **1994 Proc. 3rd Quarter 419.**

An association of guaranty funds recommended that the guaranty funds have the exclusive right to appoint and direct legal counsel retained to defend liability claims. The working group decided to add a provision to Paragraph (4) giving the association the right to choose legal counsel for the defense of covered claims. **1994 Proc. 3rd Quarter 419.**

Section 8 (cont.)

B. A suggestion was made by an association of guaranty funds to amend Subsection B(3) to afford guaranty associations the right to intervene in a proceeding involving an insolvent insurer. Some members of the working group expressed concern that this provision would result in the estate incurring unnecessary litigation expenses. Another concern expressed was that other creditors would, by extension, also be granted a right to intervene. One regulator felt that guaranty associations should not have rights superior to those of other creditors. No amendments to this subsection were included in the recommendations adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter.**

C. The working group agreed to create an optional Subsection C providing a method of raising funds in excess of the association's normal assessment capacity to pay claims resulting from a natural disaster. This provision was patterned after legislation already enacted in one state. **1995 Proc. 3rd Quarter 586.**

The amendments adopted in 1996 included an optional Subsection C and a comment on that subsection. **1996 Proc. 1st Quarter 576.**

Section 9. Assessments

Section 10. Plan of Operation

To supplement the model bill a separate model plan of operation was also adopted. **1970 Proc. IIB 1092-1096.**

When considering revisions to the model in 1994, a suggestion was made to the working group that provision be made for disposition of dividends and other advances received by a guaranty fund from an estate. **1994 Proc. 2nd Quarter 510.**

Section 11. Duties and Powers of the Commissioner

A. The second sentence was added to Paragraph (1) in December 1972. Receipt of a copy of the commissioner's petition for insolvency upon the filing of such a petition with a court would assist the guaranty funds in beginning to prepare to handle a insolvency once declared by a court of competent jurisdiction. **1973 Proc. I 156.**

B. Subsection B contained a provision requiring the association to notify insureds and other interested parties of the insolvency. This provision was deleted in 1994. **1994 Proc. 3rd Quarter 420.**

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Section 11. Effect of Paid Claims (Previous version of model)

In 1975 the drafters considered an amendment which would have given guaranty funds immediate access to insolvent company assets, declare the guaranty funds priority creditors, and offer a “rescue” funding mechanism. **1976 Proc. I 296.**

The recommendation was not adopted by the executive committee, but was sent back to the drafting task force. **1975 Proc. I 9.**

B. On a close vote the Guaranty Fund Task Force decided to include an amendment to this section limiting covered claims to claimants whose net worth was under \$50 million. All of Subsection B was new material added in December 1985. **1986 Proc. I 340, 347.**

The task force generally favored the net worth exclusion as long as third-party liability claimants who may not have a sufficient net worth were protected. This approach would serve as an incentive to risk managers for commercial insureds to shop wisely in placing their insurance. **1986 Proc. I 431.**

The footnote in Subsection B was added to clarify the original drafter’s intent that the net worth provision apply to workers’ compensation claims. **1987 Proc. I 451.**

A working group considering amendments in 1995 was asked to lower the net worth exclusion to \$25 million but declined to make that recommendation. **1995 Proc. 3rd Quarter 586.**

C. In 1994 Subsection C was substantially amended to clarify the rights of the association as claimant in the estate of an insolvent insurer and to require receivers to accept settlements of covered claims and determination of covered claim eligibility by guaranty associations. **1994 Proc. 3rd Quarter 420.**

In late 1995 an amendment was proposed to Subsection C to address the concern of some members that guaranty association determination of covered claims not affect the receiver’s adjudication of excess claims. **1995 Proc. 4th Quarter 728.**

A second issue identified by the working group was whether the receiver should be bound to accept the guaranty fund’s determination of a covered claim and the amount paid by the guaranty fund in satisfaction of the claim. The suggested amendments addressed the concerns of regulators. **1995 Proc. 4th Quarter 728.**

Section 12. Exhaustion of Other Coverage (Previous version of model)

Section 12 was titled “Nonduplication of Recovery” from the time the original model was adopted in 1962. The title was changed in 1996 to better reflect the intent of the section. **1996 Proc. 1st Quarter 570.**

A new Subsection B was added in December 1985 requiring a person with any right of recovery under a governmental insurance program to exhaust his right there first before submitting a claim to the guaranty association. **1986 Proc. I 296, 304.** A year later this paragraph was deleted and the model returned to its original language. Instead Section 3 was amended to add an additional subsection excluding any insurance provided by or guaranteed by the government. This would have the effect of excluding flood and crop hail insurance guaranteed by the federal government from covered claims. **1987 Proc. I 421.**

A. In 1994 Subsection A was amended to clarify that “other insurance” was not limited to coverage provided by a member insurer. **1994 Proc. 3rd Quarter 420.**

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Section 12. Prevention of Insolvencies

Protection against insolvency is one of the paramount objectives of insurance regulation. Two approaches are used to achieve this objective. First, insolvency funds have been created to afford protection when insolvencies actually occur. Second, statutes have armed insurance departments with various regulatory standards, procedures and tools to prevent or reduce the likelihood of insolvencies. The drafters also questioned whether additional insolvency preventive measures should be incorporated in the model bill. **1970 Proc. I 263.**

The section was rewritten in 1983 at the urging of the guaranty funds because they felt the section imposed duties on the guaranty funds boards which were more appropriately carried out by insurance departments. **1983 Proc. I 350.** The recommended changes allowed interaction between the guaranty funds and the insurance commissioners. **1984 Proc. I 326.**

A. The old Subsection A was deleted in 1994 to address antitrust concerns. It had required the board of directors to make recommendations to the commissioner for ways to detect and prevent insolvency and to discuss and make recommendations about the status of any member insurer whose financial condition might be hazardous to its policyholders. This was replaced with a provision authorizing the board of directors to make general recommendations concerning solvency regulation. **1994 Proc. 3rd Quarter 420.**

Section 13. Credits for Assessments Paid (Tax Offsets) – OPTIONAL

A regulator stated that the E Committee requested the Task Force reconsider a solution regarding assumed claims transactions. Another regulator stated that the Working Group considered the topic twice and agreed that something should be covered by the guaranty associations. A regulator suggested optional language to avoid controversy and ensure a timely response. After extensive discussion, the Task Force agreed to further study the issue. **2008 Proc. 2nd Quarter Vol. II 10-490 to 10-492.**

A regulator recommended including two options – one option where assumed business was covered, and a second option where assumed business was not covered. Another regulator explained a third option as having two parts. This alternative would be a way to take care of all assumed claims, not necessarily with guaranty fund coverage but by means of a segregated account. The Task Force discussed comments received on these options and whether drafting notes would resolve the issue. A commissioner summarized the four existing options and the potential fifth option. The Task Force decided to draft a background summary and finalize a decision at the 2008 Fall National Meeting. **2008 Proc. 3rd Quarter Vol. II 10-368 to 10-370.**

A commissioner stated that the Committee requested that the Task Force reconsider the assumed business language by considering optional language. A regulator stated that Option Three appeared to be an interim step for when insolvency takes place before a company issues their own policies. This option would be a way to handle the previous incurred losses before the assumption. The Task Force discussed issues related to this option. **2008 Proc. 4th Quarter Vol. II 10-622.**

A commissioner stated that Option Four followed Virginia Law. An interested party stated that Option Four is the mechanism by which Virginia implemented Option One. A regulator asked for clarification on the options. Another regulator said that Option Five was an attempt to be in the middle ground. The Task Force discussed the various aspects of Option Five. An interested party stated that he had an alternative that achieved Option Five's goal through a different mechanism. Another interested party stated that the option they were most supportive of was Option Three. This option leaves parties as close as possible to the position into which they put themselves while still providing relief on a going forward basis for those people finding themselves with a new insurer, but after the transaction date, their claims would be covered just as if they had been issued by the assuming carrier. The Task Force discussed the pros and cons of Option Three. A regulator polled the members on the different options. Options One and Five, received positive support from the majority. Options Two and Three did not receive support. **2008 Proc. 4th Quarter Vol. II 10-624 to 10-625.**

The Task Force voted to send Option One and Option Five to the Financial Condition (E) Committee as optional language within the model. **2008 Proc. 4th Quarter 10-626.**

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Section 14. Miscellaneous Provisions

Section 15. Examination of the Association; Annual Report

Section 16. Tax Exemptions

Section 16. Recognition of Assessments in Rates

At the December 1972 meeting of the NAIC Property and Liability Guaranty Fund Subcommittee, it was suggested that a task force consisting of both regulators and industry actuaries and rate-making personnel create a recoupment formula under the model law. **1973 Proc. I 395.**

The task force made the following recommendations: (1) In making rates consideration should be given to past assessments paid. It is the intent of the guaranty fund law that the assessments are to be borne by the policyholders eventually through their premium payments. (2) The language is quite clear on the point that, if assessments have been paid, rates are not to be considered excessive because they contain an amount to recoup the assessments paid. Because rate-making is prospective in nature, the rating law required that due consideration be given to prospective expenses as well as past expenses. (3) The task force recommended numeric formulas considering available information from prior insolvencies covered by guaranty funds. **1973 Proc. II 396-397.**

In 1995 the working group recommended the deletion of the assessment recoupment formula because it appeared that the formula had not been utilized by any state. **1995 Proc. 3rd Quarter 586.**

Section 17. Immunity

An amendment to this section was made in December 1986. The words “... for any action taken *or any failure to act* by them ...” were added to strengthen the immunity and reflect more clearly the intent of the drafters. **1987 Proc. I 451.**

A provision was added in 1994 amendments to extend immunity to those persons substituting for a member of the board of directors. **1994 Proc. 3rd Quarter 420.**

Section 18. Stay of Proceedings

Three years after the model was originally adopted, a change was made allowing a proceeding to be stayed for six months instead of the 60 days in the original model. It was found that the records of an insolvent company were in many cases nonexistent, and it took time to determine what actions were pending. The amendment allowed the association up to six months within which to prepare a proper defense, and such time thereafter as the court may grant in its discretion. **1973 Proc. I 156.**

The liquidator of an insolvent insurance company was reluctant, in some cases, to turn over the insolvent company’s claims files to the servicing carrier. Because the association couldn’t function without access to the insolvent company’s files, the second paragraph of Section 18 was added. **1973 Proc. I 156-157.**

The language in the first sentence of this section was modified to remove the words “up to” which had preceded “six months.” It was the view of the committee that the words “up to six months” imposed an unnecessary restriction upon the staying power of the court. **1987 Proc. I 451.**

An association of guaranty funds recommended that the stay be extended to the claim filing deadline to allow the guaranty funds more time to obtain and review claim files and determine what actions need to be taken. **1994 Proc. 2nd Quarter 511.**

The drafting group declined to follow the suggestion and recommended retention of the six-month period. The group did, however, add a provision allowing the association to waive the stay in instances where circumstances justify or require quicker action. **1994 Proc. 4th Quarter 588.**

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A set of general comments had been included after Section 18 with further suggestions for drafters. When amendments were considered in 1994, one suggestion was to omit these comments. An insurer association suggested that many comments in the model were outdated and no longer applicable and should be deleted. **1994 Proc. 2nd Quarter 521.**

Chronological Summary of Actions

June 1969: Model adopted.

December 1971: Amended Section 7 to provide method for filling board vacancies and Section 8 to allow payment of claims in any order deemed reasonable.

December 1972: Amended definition of insolvent insurer and added procedures to assist the guaranty association in its duties.

June 1973: Recoupment formula adopted.

December 1978: Revised definition of insolvent insurer and added sentence to limit covered claims to those timely filed.

December 1980: Eliminated \$100 claims deductible but added sentence to retain \$100 unearned premium deductible.

December 1983: Modified Section 13 to aid in detection and prevention of insolvencies.

December 1985: Extensive amendments adopted to clarify and limit scope of act, to add definitions of "claimant" and "control" and to expand section on limits of payments. The net worth limit in Section 11 was added.

December 1986: Amendments adopted to provide for extended reporting period endorsement of a claims-made policy, to exclude flood and crop hail damage insurance provided or guaranteed by the federal government, and to make technical amendments.

September 1993: Adopted amendment to Section 7 to provide for public representatives on the guaranty fund board.

March 1995: Adopted amendments to clarify and update the model.

June 1996: Adopted amendments to clarify and update the model.

January 2009: Adopted amendments to clarify and update the model.